

The Women's Health Group



Demographic Information:

Patient Full Name: _____ Date of Birth: _____
Full Address: _____
Home Phone: _____
Email Address: _____

Check or Circle Identity

Race: White Asian Black/African American
 Hispanic/Latino American Indian/Alaskan Native
 Native Hawaiian/Pacific Islander Other
Ethnicity: Hispanic/Latino Other Refused
Marital Status: Single Married Divorced
 Domestic Partner Widowed

**** I am giving consent for pre-recorded appointment reminders & test results to be left by voice message or text at the following phone number: _____ ****

Emergency Contact Name: _____ Phone Number: _____
Relationship to Patient: _____

Insurance Information:

Primary Insurance: _____ Phone Number: _____
Subscriber Name if not Patient: _____ Subscriber DOB: _____
Subscriber ID: _____ Group Number: _____
Relationship To Patient: _____

Secondary Insurance: Please Provide if You Have Another Insurance

You MUST let us know if you have an additional insurance, especially Medicaid or Medicare. Failure to provide us with that information will result in you taking responsibility for any balance due from non-payment due to our inability to bill that insurance in a timely manner.

IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO SEE US, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO REFERRAL – YOU THE PATIENT AGREE TO PAY THE WOMEN'S HEALTH GROUP IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE **The Women's Health Group** TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO THE WOMEN'S HEALTH GROUP. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER OR FOR MY FAILURE TO PROVIDE COMPLETE INSURANCE INFORMATION.

PATIENT SIGNATURE: _____ DATE: _____

I HAVE REVIEWED THE INFORMATION PROVIDED ON THIS FORM AND ALL INFORMATION IS CORRECT; OTHERWISE, I HAVE PROVIDED UPDATED INFORMATION FOR ANY INCORRECT INFORMATION LISTED.

PATIENT SIGNATURE: _____ DATE: _____